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ABSTRACT

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"THE PRINCIPLES OF PARSIMONY IN MENTAL HEALTH CENTER OPERATIONS"

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The Principles of Parsimony in Mental Health Center Operations

by
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I. THE EFFICIENT PARSIMONY APPROACH

The movement that is promoting the development of Community Mental Health Centers across the country derives some of its motive force from the recognition of inadequate coverage and divergent standards of service in the Mental Health field. It accepts clearly a public responsibility for the provision of care for all who need it. This laudable new venture, however, bids well to stumble and falter over the problems of the shortage and high cost of trained manpower. Already, reports suggest that, even in well developed centers, there is marked discrepancy between plans and practice, between promise and product.[1] The acceptance of the challenge of comprehensive coverage makes pressing the need to delineate new principles for the deployment to our available resources. Simultaneously, we must guarantee that the quality and appropriateness of coverage is not impaired.

We are well aware today that there exists, alongside inadequate or non-existent coverage for many, a prodigality of resources devoted to a small selected group in the population. The opposite of prodigality is parsimony, the wise and efficient use of limited resources. In planning for mental health centers some organizing principles utilizing the concept of parsimony are an obvious necessity. Yet the comparison of these two opposites is an uncomfortable one, as it may imply a lowering of the standard and quality of care in achieving the new objectives. Because of this implication, the principles of parsimony need to be supplemented by principles that guarantee effectiveness of the interventions and a strong proviso against any dilution of activities to the extent that they may have little meaning for the final consumer. The concept

that we discuss here is a more judicious distribution of resources to implement whatever is needed for effective intervention with the least expenditure of effort, activities and time of both professional and patient, but still sufficient to guarantee an intervention that is significant. This blend of principles we have chosen to call "effective parsimony". Obviously what can be proposed are guidelines for the planning of a center and some translation of these into viable methods of operation.

As many of us remember from our days of English grammar, to parse means to separate all the least parts of a sentence and to state their relationship to each other. To be parsimonious means to be stingy, according to Webster, and excessively frugal. To be parsimonious in work, in this context, means to deploy the least effort required to achieve the desired end and goal. Some years ago Dr. Clair Calhoon, a colleague of ours in Atlanta Regional Office of National Institute of Mental Health translated the principles of parsimony into the treatment field as follows: "To be clinically parsimonious is to provide care that requires the least disruption of the patient's life, the least separation from family and job, providing care at the least cost possible and using the least intervention required to effect the therapeutic and rehabilitation goals."

In 1961, Dr. Gerald Caplan in his book, "An Approach to Community Mental Health,"[2] said "Psychiatric intervention is an artifact in the patient's life which should be kept minimum in effort and time in order to maximize the possibility of the operation of spontaneous strengths of the patients and his psychosocial environment." To put all of this into the vernacular, whereas Nathan Bedford Forest tried to get there "firstest with the mostest," those of us who pursue the principles of parsimony will try to achieve the "mostest with the leastest." We recognize that it is easy to confuse being parsimonious

as stingy. Here we use parsimonious as working effectively without waste; achieving our goals of care by doing neither more nor less than needs to be done without dissipating time or energy. As Caplan implies, it is also important to recognize that probably the quality of care has as much to do with the utilization of strengths as it does with the remediation of weaknesses. The recognition of strengths and social competences and their deliberate promotion by cognitive and affective methods are principles of a working philosophy that are essential to make the least measured dosage of care become a viable principle of intervention.

This "effective parsimony" or "conservation approach" to health treatment is not necessarily new. It has been applied in the field of physical medicine for centuries where nature has been seen of necessity as the great healer and the doctor's intervention as only the hand maiden of this process. Within this sphere lies another important corollary and responsibility -- the need to distinguish reliably between areas where the health conservation approach is justified by our knowledge of the natural course of the illness, as opposed to those conditions where only a radical approach will be effective for recovery. Perhaps it is the absence of such parallel knowledge in the mental health field that has led to the tendency to apply our ultimate weapons (the psychotherapist) in every case accepted and provide very little for the unlucky remainder of people. Psychotherapy and individual treatment should properly be reserved for cases in which no other intervention is likely to be successful, thus becoming the "surgery of the mental health field?".

Even in mental health work a parsimonious approach is by no means new. The time seems ripe, however, that this be clearly stated as one of the basic necessary and guiding principles in mental health center development and operation. Some of the medical profession do not seem by their actions to under-

stand this necessity for parsimony. In fact, some of the values pursued by some of our best trained clinicians are in direct opposition to the principles of parsimony. Their distribution of care, certainly a matter of clinical judgment, implies a strong belief in the necessity and desirability of prodigiously expensive long term intensive work. Too frequently, psychotherapy is the sole intervention considered. Any alternative is viewed as insufficient and perhaps unprofessional. Increasing experiences suggest that the answer lies between these two viewpoints and that the flexibility of the system needs to guarantee the availability of several appropriate alternatives. Neither arbitrary insistence on psychotherapy or arbitrary parsimoniousness will lead to a great deal of effectiveness if either extreme is the sole and overriding principle of operation. The use of parsimony will mean modification of some time honored and well justified values held by medical and other clinical disciplines. The practice of medicine and its speciality, psychiatry, has been mainly built up around the philosophy that each case must be cared for by its ultimate weapon, namely, the physician or the psychiatrist himself. Long and well-documented experience heavily reinforces the value of this practice, but its negative consequences have often been ignored. For instance, we have long valued the personal attention of the diagnostic hour and the 50-minute psychiatric session. What we have not realized is that when the psychiatrist goes behind his door for 50 minutes with a patient he is, in effect, having to close the door on 5-7 other patients who are left outside with no psychiatric care. The criticism clearly is not against the value of the individual psychotherapy but is a plea for consideration for those who, by the present methods, are excluded from any care at all. There are increasing signs of polarization between community mental health on the one side, and the practice of individual care on the other. They are not mutually exclusive, and in fact, the movement to separate them will debilitate both. The plea is for a consideration of alternatives that will

allow greater coverage and dispersal of the resources and the more judicious and appropriate selection for psychotherapy of those cases where there is a clearly defined and predictable need for it as the only effective intervention modality.

To be sure, these untreated cases are not out in the waiting rooms. No, instead they are waiting, unrecognized, out in the communities or they are searching for help from some non-medical agency. Unfortunately, some of us in medicine have grown much too used to defining the need, or defining the problem itself, in terms of those who show up for treatment. We have found ourselves so totally involved with those who do turn up for treatment that we have often failed to reach out for the untreated accumlating in the caseloads of public welfare and public health and other resource facilities. Too much of our case finding to date has been passive receptive, sitting in our offices and clinics instead of active searching and caring for others needing help in the community.

Why then is some parsimony necessary in the operation of a mental health center? First, it is clearly required if we ever hope to get the job done of providing comprehensive coverage for the population of a catchment area. Dr. George Albee[3] has documented our desperate manpower shortage. Various studies give estimates of the hidden untreated mental health load within center catchment areas. These various estimates indicate that 50% or more of the patients seen in private medical practice, 7-14% of school children, 36% of public health nurse patient loads[4] 35-40% of the welfare caseloads, and many other clients of courts and correctional agencies have significant mental health problems needing care. The American Hospital Association published estimates that about 12% of those needing psychiatric care see a psychiatrist, and only 25% reach a

physician for care.[5] Surely we cannot assume that our fledgling, relatively undermanned centers will be able to provide full clinical coverage for a population of 75,000 to 200,000. Many of us realize we must find ways other than direct clinical care to meet or reduce the need.

Many of us who have attempted to visualize the mental health problem in its entirety, have come to believe that the mental health professions can no longer ignore the hidden untreated caseloads in the community. Just as sincerely, we cannot hope to bring all these untreated cases to care by our ultimate weapon of the past, the clinician and psychotherapy. Some of us have come to believe that it is not only impractical and unfeasible, but it is not always desirable to bring every case to the psychiatrist's personal attention. Many of us have taken too little time to spell out the alternatives. It seems necessary now that we actively and honestly confront our colleagues, the clinicians, and the general public, with the probability that a treatment focused mental health center will simply not be enough. We have to resist implying to the public either by omission or commission, that just building a larger treatment program will solely meet the need, though we must indeed increase our treatment resources. What we must communicate clearly is that the center, if it is adequately to serve its community, has no alternative but to be continually aware of and implement judiciously, the principles of parsimony and conservation. These principles can be stated along the following five lines, realizing that there will be exceptional cases and situations:

1) The least disruptive intervention is the first treatment of choice.
2) The least separation from family and job will be sought.
3) The least expensive treatment will be used first.
4) The least extensive intervention will be used first.
5) The least trained intervenors will be used first.

These five principles of care clearly point out what we mean by the judicious use of the laws of parsimony in center planning. Let's add to these principles two necessary safeguards:

1) Efficiency will not be construed as synonymous with effectiveness.

2) Effectiveness of intervention and the need for it can be a supraordinate consideration over parsimony. The objective is to guarantee to all what is both necessary and sufficient for their rehabilitation.

II. HOW CAN WE IMPLEMENT THE PARSIMONIOUS APPROACH?

It is becoming increasingly evident that the ability of the mental health center to cope with the wide range of demands and meet the needs of a complete catchment area will require several drastic changes in philosophy, organization, and operation. Most certainly, we will have to abandon patterns of considering all admissions as "clinical admissions" and move toward a differentiation of admissions into clinical, rehabilitative and social management categories.

What then does all this mean in terms of program organization? First, it means that most people ought to be cared for in their home and near their job settings instead of in clinics and hospitals. Secondly, it means that most people will be cared for first by frontline agencies or caretakers, family, or self. It means that only an acute emergency or failure of a time trial of "Frontline" care will lead to bringing the person into direct contact with the professional clinical staff. Thirdly, it means that some clinical personnel will spend a high percentage of their time in frontline diagnosis, intake, treatment planning and disposition to appropriate alternatives to clinical care. They will deploy their expertise at this point to perform truly enlightened triage, a relatively undeveloped area of mental health expertise. This move to put our best diagnostic talent on the frontline, to work very closely with the caretakers, may have a visible payoff in more efficient utilization of alternative forms of care. Clinical personnel will work conjointly with caretakers to determine the kind of "frontline care" on "time trial" that will be used and to select out at that point, those cases that will not be served sufficiently by such methods.

Fourth, it means that a major portion of the time of the scarce clinical

personnel will be spent supplying indirect consultative support, training, and information to caretakers. Fifth, it means that major effects will have to be made to reach out to the high risk groups so often found among the clientele of other agencies, so that high risk groups may be screened for vulnerable individuals and problems in their incipient stages. It means that knowledge gained in this way will have to be utilized to help agencies and organizations review and revise their programs and practices better to serve those for whom they have an existing and continuing care mandate. It means that emphasis will have to be given to collaboration in preventive activities with the human service agencies in the community to utilize the least intervention possible rather than waiting until heroic repair efforts of a clinical nature may be needed. Some of the other changes needed are:

1. Diagnostic Labeling and Disposition.

I sense that we will have to move away from prime dependence upon a system of psychopathological labelling toward greater utilization of "disability level" diagnoses. The level and the nature of the disability then must be more carefully linked to the kind of intervention required, so that the disposition to care is related to the nature and severity of the disability. Instead of defining disposition in terms of a person's need to go to a certain clinical facility, i.e., outpatient, inpatient, day hospital, etc., I believe we should move toward defining his diagnosis and disposition in terms of the kinds of help needed. For instance, I think if we begin to classify our services in terms such as: protection, removal from stress, self-understanding development, role re-training, resocialization, relationship building services, family reorganization, re-entry to work, or other such pragmatic terms, then it might be much more easy for us to think in terms of disposition to non-clinical

resources, at least for "time trials" to see whether these interventions would be helpful. I think one of the happy results of such a reorganization of our diagnostic approach would be that both patients, family and staff would more clearly understand the reasons for various dispositions and assignments and there might be less failures to appear for help. By contrast, assignment to inpatient, outpatient doesn't communicate very much to family about why or what for. I think we need a new language of care that is meaningful to the recipients of care and their families but that is also a diagnostic label that indicates the kind of intervention necessary. I would categorize this as a kind of "why language" that talks in terms of treatment purpose, not facility or psychopathology. Hopefully, the adoption of such a language of diagnosis and disposition would expedite referrals, orchestration, and utilization of services.

2. Using the Best Trained Staff at Portals.

Since the amount of clinical care that we can really provide and pay for will have to be limited, it becomes very, very necessary to bring our best trained brains to the point of triage where disposition is to be made. These brains need to be trained not only in standard pathological diagnostic skills but to be fully informed of a wide range of services that would fall under the purposes related in the paragraph above. It is most important that every portal of the center be thoroughly equipped with and each staff person briefed on, a comprehensive set of data on the services of all of the helping services in the community, the criteria for referral and admission, and copies of the current agreements to receive patients from the center triage points. It is most important that the administration of the center have spent a considerable amount of time that it will take to build up the referral and liaison agreements so that an emergency clinic staff member in the middle of the night has the mandate and the right to make referrals to the proper resource without having to admit them into expensive, costly hospitals, to hold them until disposition can be

be made.

The diagnosticians at this triage point need to be able to (1) sense the severity, the risks, and the consequences of the problem situations confronting them. (2) They need to be able to assess the level of disability present or threatened. (3) They need to be able to define for the beginning stage of the service, the entire range of services needed, not just in facility or agency terms but in terms of the purpose classification given above. (4) They need to be philosophically ready to select and intellectually prepared to implement the most parsimonious way of providing the service needed, or a time trial of it. (5) They need to be invested with the power to mobilize the appropriate resources needed.

3. Reorganization of Portals to Meet the Population's "Willingness to Use Patterns."

It seems to me that too many centers are being set up with one portal, an outpatient clinic in the daytime and an emergency clinic at night. Such an organization of portals assumes that the public will define their problem in medical terms and come to a medical facility for help. We have abundant evidence that many individuals, especially in the early stages of their disability, do not define their problem as one requiring medical intervention. Unless we reorganize our portals of care to fit the population's perception of how it will seek help, we will end up serving only a part of the population and failing to get to disabilities at an early stage in their development when they might be more amenable to more parsimonious intervention. Unfortunately our opening up the access of the center to a wide range of portals compounds our problem of bringing the best brains to the triage point. Consequently, the considerable experimentation and study are going to be needed in each locality to (a) define the "willingness to use" precepts of the various sub-groups of the population,

(b) set up and advertise the portals for help, and (c) train each of these portal staffs with the sensitivities and knowledge they need in order to wisely make use of the whole circle of services available that may be required to meet the problem.

If you were to ask me "what are some of the other essential things that must happen in order to convert a center to greater operations on the basis of the principles of parsimony" I would like to list the following briefly. (1) I think that rehabilitation is going to have to be a greater and more important part of the service. Tradition and the preconceived patterns of care implied in the mental health center act still conceptualize the center predominantly in clinical terms. I think the mental health center act ought to be re-drafted with much more emphasis placed upon the development of various kinds of rehabilitation and resocialization services as part of the main core of the center. Again, I firmly believe that we are going to utilize rehabilitation and re-education services more and more as one of the principal leverages in trying to meet people's needs. (2) I believe that we are going to have to rewrite the mental health centers act, and the state financial enablement procedures that accompany it, to provide for a step-by-step development of centers and the contract financing of collateral services in other community agencies. Despite the Republican Party's strong pressure, through Melvin Laird, to see that the mental health center legislation, when originally enacted, was not just another grant-in-aid program; despite their pressure that there should be at least five basic services and a "bold leap forward" they unfortunately created a financial enablement dilemma which has allowed the larger communities with larger tax bases to take on the center programs but severely handicapped the smaller political jurisdictions with low tax bases. The political realities

in small areas is that the tax dollar does not expand fast enough to take on a brand new agency in town that frequently will require immediately more money than is being spent for public health or many more well established agencies. In addition, every local appropriating body--county or city-- has a long line of people waiting for appropriations. The time limits imposed by the mental health legislation propels local leadership into asking for immediate funding. In too many places this was met by the normal American response "take your turn," "go to the end of the line because others have been waiting in line for a long time". In one county in which I have worked there were 26 programs ahead of us in the line and the expansion of the tax dollar didn't look like it could accommodate even a minimum request on our part until some five or six years hence. Furthermore, insisting to get ahead of the rest of the agencies in line in many places would seriously jeopardize your membership and acceptability in a circle of agencies, many of them older in the community and just as convinced as you are of the essential character of their work.

The second type of revision of the Enablement Legislation and Procedures needs to more thoroughly accept and implement the fact that we cannot solely conduct the business of meeting the needs of the population in the geographic area, catchment area. With the recognition that some 7 to 14% of school children, some 36% of the public health nursing caseloads, or some 45% of the welfare load are in reality mental health clientele, and with the further recognition that these people must be handled through these agencies, it now becomes urgent that both the legislators and the planners of mental health centers thoroughly acknowledge and plan for strengthening the mental health relevant roles of these agencies. In order to do this, they must be equipped with the appropriations that will enable the center to subcontract important parts of the program with many other kinds of agencies in the community which are portals for care and vehicles for

care of the clientele we seek to serve. In sum, the fully comprehensive center needs to be in collaboration, as part of a circle of services, and needs to be philsophically and economically equipped to utilize the comprehensive outreach opportunities that are available through interagency collaboration and contracts. Until the money is specifically there and recognized as a key part of the center game, many centers in periods of economic scarcity are going to pull their funds in for their in-house use and therefore lose the opportunity to be truly comprehensive.

3. Financing of Outreach Aspects of Center Program.

The previous medical model of center operations of remaining in passive reception of cases will have to give way to a positive, active outreach program if there's any hope of becoming comprehensive and especially mounting a preventive impact for the center program. Unfortunately the economic leverage and pattern of financing of centers are all on the side of their remaining passive receptive. Why reach out for service to more people when you scarcely have the staff and the money to serve those who appear at the door? Unless the mental health center act and center financing by the states is rewritten to specially financially implement consultation, education, prevention, and active outreach to the unserved, there is little opportunity then to really reach a level of comprehensive service. Regrettably, there are individuals who do not define their illness in mental health terms; therefore, do not avail themselves of early or preventive services. There are also individuals who are unmotivated, part of whose illness is to remain wallowing in the particular problem from which they suffer. In addition, there are those who define their problem as fate, or poverty, or sin. There are others who find medical or mental health services unacceptable or a stigma too great to bear. Add to these the individuals who refuse treatment as a personal right and you will have a con-

siderable body of pathology and disability in the population for whom it is difficult to provide services. Unless specific funds are provided for outreach aggressive case-finding and service program out in neighborhoods through other agencies and through other modalities, these services will not get provided and centers will slowly ossify back into the clinical program only. A great deal of experimentation about crisis intervention in the home, social action in the ghetto, and mobilizing self help sources must be undertaken in order to complement the passive receptive concept of mental health care in the past with a new active outreach.

Part and parcel of the active outreach in getting to the people difficult to reach will be the transportation services in connection with care. Not only transportation services of staff into the neighborhood but also 24-hour on-call "service guide" services similar to those that we are pioneering within rural North Carolina are needed to get people to service. We have been experimenting with a sort of "omsbudsman on wheels," who provides pre-service and aftercare, as well as transportation, education, interpretation, and outreach. We sense that the transportation problem is critical in the matter of comprehensive service, especially in rural areas.

SUMMARY

Much of this may not appear new. Much of it has been said before so many times, but let us ask "are these statements really being put into operations?" We hear of resources being made available for more beds, more clinics, more day hospitals, more outpatient services, but there seems less emphasis on setting up staff and resources to build the parsimonious patterns of frontline care. The mental health center is not just another bigger and more complex clinical operation, just a bigger, more extensive hospital and clinic. There is the

opportunity now to break with the existing pattern of services bound by tradition and face the reality that a great deal of the care and prevention programs of mental health centers will be non-clinical in nature. We can at this point clearly indicate that the majority of the mental health problems in the community must be met and dealt with where they occur, in the home, in the schools, in the court, in the welfare department, health unit, or other agency. Without beds, daycare, and outpatient services, these frontline programs would be without the adequate backup resources for specific cases. But if these backup resources are required to handle both frontline and the more specialized cases they will soon become swamped.

A center in this sense will have no alternative but to operate on the principles of parsimony and will have to interpret to its community that in the long run the best care requires the least life disruption, the least separation from supporting relationships, the least percentage of scarce professional time, and employs the least intervention that is necessary and effective on a time trial basis. In the face of overwhelming service obligations and scarce resources, parsimony has a common sense appeal; but if applied unthinkingly it may so dilute activities that their meaning becomes lost. As ever, we must use constant professional evaluation to strike the right balance between coverage and effectiveness.

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